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August 19, 2014

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Final Rule: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder

This letter gives notice of an adopted rule: MaineCare Benefits Manual, Section 29, Chapter II, Support Services for Adults with Intellectual Disabilities or Autistic Disorder. The Department is adopting four new services: Assistive Technology, Career Planning, Home Support-Quarter Hour and Home Support-Remote Support. Additionally, the Department split Work Support into two separate services: Work Support-Individual and Work Support-Group.

The Department is also adopting performance measures. The primary goal of performance measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance goals and performance measures have been established to monitor quality, inform, and guide reimbursement decisions and conditions of provider participation across MaineCare services. The focus on performance measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

Other changes to the rule include:

- The addition of seven (7) new definitions: Activities of Daily Living, Agency Home Support, Independent Contractor, Instrumental Activities of Daily Living, Medical Add On, Prior Authorization and Utilization Review.
- Removal of the definition of Summary of Authorized Services.
- A requirement for Section 29 applicants and their planning teams to estimate the annual budget of services in the course of applying for waiver services.
- A requirement that the Personal Plan for members electing the Home Support-Remote Support Service incorporate a safety/risk plan.
- The addition of limits on Community Support Services, Assistive Technology Services, Career Planning Services, Counseling Services, Consultation Services, Employment Specialist Services and Home Support-Remote Support Services.
- The addition of new provider qualifications for those Direct Support staff that provide Home Support Services, Work Support-Individual Services, Work Support-Group Services, Employment Specialist Services and Career Planning Services.

Other technical language changes are also being adopted. The reason for the rule changes are to comply with the budget bill P.L. 2013, chapter 368 directing the Department to add Assistive Technology to this waiver. The Department is complying with Resolve, Chapter 24, LD 8, Resolve, Directing the Department of Health and Human Services to Provide Coverage under the MaineCare Program for Home Support Services for Adults with Intellectual Disabilities or Autistic

Disorder. This Resolve directs the Department to add Home Support as a covered Service to this waiver. The Department is also complying with a CMS directive to separate Home Support into separate services. The Work Support and Career Planning changes are to comply with LD 8, Resolve, Directing the Department of Health and Human Services to provide coverage under the MaineCare program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder.

A public hearing was held on April 15, 2014. The comment deadline was April 25, 2014. The rule is effective September 1, 2014.

The Department made numerous changes to the Final Rule from the Proposed Rule, in response to comments, and also on the advice of the Office of the Attorney General. A list of the changes and the reasons for the changes can be found in the document, "Summary of Comments and Responses".

Rules and related rulemaking documents may be reviewed at and printed from MaineCare Services website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or, for a fee, interested parties may request a paper copy of rules by calling 207-624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A copy of the public comments and Department responses can be viewed at and printed from MaineCare Services website or obtained by calling 207-624-4050 or TTY: 711.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

Notice of Agency Rule-Making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder.

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department is adopting four new services: Assistive Technology, Career Planning, Home Support-Quarter Hour and Home Support-Remote Support. Additionally, the Department split Work Support into two separate services: Work Support-Individual and Work Support-Group.

The Department is also adopting performance measures. The primary goal of performance measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance goals and performance measures have been established to monitor quality, inform, and guide reimbursement decisions and conditions of provider participation across MaineCare services. The focus on performance measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

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This rule change is not anticipated to have any adverse impact on small businesses or impose any additional costs on counties or municipalities.

[HTTP://WWW.MAINE.GOV/DHHS/OMS/RULES/INDEX.SHTML](http://www.maine.gov/dhhs/oms/rules/index.shtml) for rules and related rulemaking documents.

EFFECTIVE DATE: September 1, 2014

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29.01 INTRODUCTION

Support Services for Adults with Intellectual Disabilities or Autistic Disorder are for adults who either live with their families or live on their own. Support Services are also designed to support members in the workplace. Support Services are provided under a Federal 1915 (c) waiver that meets Federal standards. Eligible MaineCare members may only receive services under one waiver benefit at a time. MaineCare members can receive covered services as eligible and as detailed in other Sections of the MaineCare Benefits Manual.

To be eligible for this benefit, members must meet medical eligibility, financial eligibility and require the level of care in order to receive services. The planning process identifies members' needs, which must be documented in a personal plan and then authorized. If all available funded openings are full the member is placed on a waiting list as described in Section 29.03.

Effective
9/1/14

29.02 DEFINITIONS

29.02-1 Activities of Daily Living (ADL) are:

- A. Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed;
- B. Transfer: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
- C. Locomotion: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
- D. Eating: How person eats and drinks (regardless of skill);
- E. Toilet Use: How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
- F. Bathing: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
- G. Dressing: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

29.02-2 **Autistic Disorder** means a diagnosis that falls within the category of Pervasive Developmental Disorders (to include Autistic Disorder, Pervasive Developmental Disorders-not otherwise specified, Asperger's Syndrome, Rett's Disorder and Childhood Disintegrative Disorder), as defined in Section 299.0-299.80 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA § 6002 and accompanying rules.

Effective
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29.02-3 **Agency Home Support** means a Provider Managed Service Location that routinely employs direct care staff to provide direct support services.

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29.02 DEFINITIONS (Cont.)

Effective
9/1/14

29.02-4 **Authorized Entity** is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

29.02-5 **Case manager** is a person who works in determining, coordinating, and arranging appropriate and available services for members and facilitating the development of the Personal Plan. This person may also be referred to as an Individual Support Coordinator.

Effective
9/1/14

29.02-6 **Correspondent** is a person designated by the Maine Developmental Services Oversight and Advisory Board to act as a next friend of a person with Intellectual Disabilities or Autism.

29.02-7 **Designated Representative** means the DHHS staff or Authorized Entity authorized by DHHS to perform specified functions.

29.02-8 **Direct supports** are a range of services that contribute to the health and well being of the member and his or her ability to live in or be part of the community. Direct support services may include personal assistance or services that support personal development, or services that support personal well being. Home Support, Community Support, Employment Specialist Services and Work Support are direct supports. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct supports include the following:

Personal assistance is assistance provided to a member in performing tasks the member would normally perform if the member did not have his or her disability. Personal assistance may include guiding, directing, or overseeing the performance of self-care and self-management of services.

Self-care includes assistance with eating, bathing, dressing, mobility, personal hygiene, and other services of daily living; assistance with light housework, laundry, meal preparation, transportation, grocery shopping, and assistance with health and nutrition maintenance, including assessing well-being and identifying need for medical assistance; complying with nutritional requirements as specified in the Personal Plan; administration of non-prescription medication that are ordinarily self-administered; and administration of prescription medication, when provided by a person legally authorized to assist with the administration of medication.

Self-management includes assistance with managing safe and responsible behavior; exercising judgment with respect to the member's health and well-

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29.02 DEFINITIONS (Cont.)

being; communication, including conveying information, interpreting information, and advocating in the member's interests; managing money including paying bills, making choices on how to spend money, keeping receipts, and expending funds with the permission of a member's representative payee. Self-management also includes teaching coping skills, giving emotional support, and guidance to other resources the member may need to access.

Services that support personal development include teaching or modeling for a member self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in services to promote social and community engagement; participation in spiritual services of the member's choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise.

Services that support personal well-being include directly or indirectly intervening to promote the health and well-being of the member. This may include identifying risks such as risk of abuse, neglect or exploitation; participating in a member's risk assessment, identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. In the absence of a plan, intervention must be consistent with DHHS's rule governing emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with reporting requirements.

Effective
9/1/14

29.02-9 **Employment Setting** for either Work Support-Individual or Work Support-Group means a work setting that is integrated with non-disabled employees in a variety of ways. The job must be one that is available to a non-disabled employee with the same expectations for the member's job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Staff providing Work Support or Employment Support Services

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29.02 DEFINITIONS (Cont.)

at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from [AbilityOne](http://AbilityOne.org) (<http://AbilityOne.org>), the federal workforce guidelines associated with this funding source will apply to the services funded by the NISH contract. The member can be on the employer's payroll. Members may receive additional employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case by case basis to have the support agency offer and provide this supervision as long as the above conditions are met.

Effective
9/1/14

- 29.02-10 **Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.
- 29.02-11 **Instrumental Activities of Daily Living (IADL)** include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.
- 29.02-12 **Intellectual Disability** means a diagnosis of mental retardation as defined in Section 317-319 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001. The terms "mental retardation" and "intellectual disability" are used interchangeably in these regulations. Use of the term "intellectual disability" in no way alters the criteria for eligibility set forth in § 29.03-2(B).
- 29.02-13 **Medical Add On** is a component of Home Support, Community Support, Employment Specialist Services, Work Support-Individual and Work Support-Group and is included in the established authorization (as described in Section 29.04-1). It is not a separately billable activity. Billing may not exceed the Home Support, Community Support, Employment Specialist Services, Work Support-Individual and Work Support-Group authorized units of service. Documentation must clearly identify and support periods of such activity. Refer to Appendix I for more information.
- 29.02-14 **Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

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29.02 DEFINITIONS (Cont.)

Effective
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- 29.02-15 **Mental Retardation** means a diagnosis of Mental Retardation as defined in Section 317-319 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations. Use of the term “intellectual disability” in no way alters the criteria for eligibility set forth in s. 21.03-3(B).
- 29.02-16 **On Behalf Of** means the provision of a service for the benefit of individual members that and is not necessarily a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable service. Billing “On Behalf Of” is not necessarily a habilitative service, it may not exceed a member’s Home Support, Community Support, Employment Specialist Services, and Work Support authorized units. Documentation detail must clearly identify and support periods of such service.
- 29.02-17 **Personal Plan** is a member’s plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only covered services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 29.04 are met.
- 29.02-18 **Prior Authorization** is the process of obtaining prior approval as to the medical necessity and eligibility for a service.
- 29.02-19 **Qualified Intellectual Disability Professional (QIDP)** is a person who has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor’s degree in a human services field including but not limited to: sociology, special education, rehabilitation counseling, and psychology, as specified in title 42 Code of Federal Regulations (CFR) 483.430, paragraph (B)(5), 2010.
- 29.02-20 **Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety,

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29.02 DEFINITIONS (Cont.)

and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.

Effective
9/1/2014

29.02-21 **Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services on a prospective, concurrent or retrospective basis.

29.02-22 **Year** services are authorized on the state fiscal year, July 1 through June 30.

29.03 DETERMINATION OF ELIGIBILITY

Eligibility for this benefit is based on meeting all three of the following criteria; 1) the member must require ICF/IID level of care as set forth under the MaineCare Benefits Manual, Chapter II, Section 50. 2) the member must have eligibility for MaineCare are determined by the DHHS Office for Family Independence (OFI), and 3) a funded opening is available.

29.03-1 **Funded Opening-** The number of MaineCare members that can receive services under this Section is limited to the number, or “funded openings,” approved by the Centers for Medicare and Medicaid Services (CMS) and the appropriation of sufficient funding by the Maine Legislature. Persons who would otherwise be eligible for services under this Section are not eligible to receive services if all of the funded openings are filled or if there is not sufficient funding.

29.03-2 **General Eligibility Criteria**

Consistent with Subsection 29.03-1, a person is eligible for services under this Section if the person:

- A. Is age eighteen (18) or older; and
- B. Has an Intellectual Disability or Autistic Disorder; and
- C. Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and
- D. Does not receive services under any other federally approved MaineCare Home and Community Based waiver program; and
- E. Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual; and
- F. Lives with family or on their own; and

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29.03 DETERMINATION OF ELIGIBILITY (Cont.)

- G. The estimated annual cost of the member's services under the waiver is equal to or less than fifty percent (50%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.

29.03-3 Establishing Medical Eligibility

In order to determine medical eligibility, the member and case manager must provide to DHHS the following:

- A. A completed copy of the assessment form (BMS99) or current functional assessment approved by the Department and
- B. A copy of the member's Personal Plan approved and signed by the member or guardian and the case manager and any other relevant material indicating the member's service needs. The Personal Plan must be less than six (6) months old at the time of the member's medical eligibility determination or redetermination.

Based on review of the Assessment Form, the Personal Plan, a Qualified Intellectual Disability Professional designated by DHHS will determine the member's medical eligibility for services under this Section.

DHHS shall notify each member or the member's guardian in writing of any decision regarding the member's medical eligibility, and the availability of benefit openings under this Section. The notice will include information about the member's right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the MaineCare Benefits Manual.

If the member is found to be medically eligible, DHHS must send the member or guardian written notice that the member can receive ICF/IID services or services under this Section. The member or guardian must submit to the case manager a signed Choice letter documenting the member's choice to receive services under this section.

29.03-4 Calculating the estimated annual cost

Prior to formal determination of eligibility for services under this section, each applicant and their planning team must identify the required mix of services to meet the applicant's needs and to assure their health and welfare. The applicant and their planning team shall submit a detailed estimate of the annual ~~cost~~ budget of services identified in the Personal Plan, including the specific services and the number of units for each service.

Effective
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29.03 DETERMINATION OF ELIGIBILITY (Cont.)

29.03-5 Waiting List

DHHS will maintain a waiting list of eligible MaineCare members who cannot get Section 29 Services because a funded opening is not available. Members who are on the waiting list for the benefit services shall be served chronologically based on the date the Designated Representative determines eligibility for the waiver.

Effective
9/1/14

A member has sixty days from the receipt of notification by DHHS of a funded opening to respond with intent to accept waiver services. A member has six months from the receipt of notification to start receipt of services. If the member fails to respond with intent to accept the funded opening within 60 days of this notice or fails to begin services within 6 months, the member shall be removed from the waitlist. A member may reapply at any time for waiver services.

29.03-6 Determination of Continuing Eligibility

When making a determination of continuing eligibility, the case manager will submit an updated Assessment Form (BMS 99) or current functional assessment approved by the Department to DHHS twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. If the updated Assessment Form is not received by the due date, reimbursement for services will be denied until receipt of the assessment form and Personal Plan. Reimbursement for services will resume upon receipt of the Assessment Form and Personal Plan.

Whenever significant changes occur that alter level of care, the case manager will submit an updated Assessment Form to DHHS. The case manager must complete and submit all waiver documents including the BMS 99, or current functional assessment approved by the Department and the updated Personal Plan to the Resource Coordinator thirty (30) days in advance of the annual redetermination date.

Effective
9/1/14

29.04 PERSONAL PLAN

If the member or guardian chooses services under this Section, the request for services must be submitted to DHHS or its Authorized Entity. As part of the planning process, the member's needs are identified and documented in the Personal Plan. Except for residential services, other services shall be provided to the member within ninety (90) days.

Effective
9/1/14

29.04-1 Prior Authorization for Reimbursable Services

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS or its Authorized Agent for Prior Authorization in order for the services to be reimbursed. Requests will be reviewed by DHHS or its Authorized Entity, and may be examined and evaluated by DHHS or its Authorized Entity, before units of service are authorized. All prior authorizations are time-limited, and the length of the

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29.04 PERSONAL PLAN (Cont.)

authorization may vary by member and service as documented in the Personal Plan. Upon expiration of an authorization, a new authorization must be obtained before reimbursement may be provided for the service.

DHHS and its Authorized Entity reserve the right to conduct Utilization Review of any service authorized under this Section, applying the service-specific eligibility standards set forth in this Section. DHHS and its Authorized Entity may terminate or revise a service authorization upon finding that the member no longer satisfies the eligibility standards for the service or level of service authorized.

29.04-2 Personal Plan Requirements

The case manager will ensure that a Planning Team is convened to initiate development of the Personal Plan prior to services being initiated. The plan must be less than six (6) months old at the time of the member's eligibility determination or redetermination. The Personal Plan must contain at a minimum:

- A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including all other services that may not be covered under this section but that the member identifies and may pursue;
- B. The frequency of provision of the services;
- C. How services contribute to the member's health and well-being and the member's ability to reside in a community setting;
- D. The member's goals for strengthening and cultivating personal, community, family, and professional relationships;
- E. The role and responsibility of the Direct Support Professional, the Employment Specialist and the member's other service providers in supporting the member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;
- F. Members who chose to receive Home Support- Remote Support must have a safety/risk plan, which shall describe the potential risks to the member's health and welfare while receiving Home Support- Remote Support and the reasonable steps to alleviate those risks; and
- G. In order for the Personal Plan to be approved, the Personal Plan must include signatures of the member, guardian, if applicable, and case manager. Participants must sign and date any updates to the Personal Plan.

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29.04 PERSONAL PLAN (Cont.)

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The Personal Plan will be used by DHHS or its Authorized Entity to identify the type and units of authorized services the member may receive under this Section. If more than one provider is reimbursed for the same category of direct supports, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

All Providers must ensure that notice of the Grievance process outlined in 14-197 CMR Chapter 8 is regularly provided to members served by the Provider. Providing notice includes, at a minimum, ensuring that written notice of the grievance process is provided to the member and/or their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the Provider; and posting notice of the grievance process on any website maintained by the Provider. In addition, the provider must ensure that all staff are trained in the grievance process.

29.04-3 Planning Team Composition

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner that is respectful and reflective of the member's preference. The planning team may include the following members, if applicable:

- A. case manager;
- B. The member;
- C. The member's parent, guardian or Correspondent;
- D. The member's advocate or friend or any additional individual invited by the member;
- E. Direct Support Professional providing services to the member;
- F. Staff from the member's Home Support, Community Support, Work Support, Employment Specialist Services, Assistive Technology and Career Planning Provider; and
- G. Any professionals involved or likely to be involved with the member's Personal Plan.

29.04-4 Updating the Personal Plan

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The member's Personal Plan must be revised and updated at least annually, and in addition when other significant changes occur relating to the member's physical, social, or psychological needs, or the member's significant progress toward his or her

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29.04 PERSONAL PLAN (Cont.)

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goals. When a member's residential placement changes the case manager must reconvene the Planning Team to revise and update the Personal Plan, within thirty days of the move. Planning meetings must be held both prior to and subsequent to the planned move of a member to a new residence in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

29.05 COVERED SERVICES

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29.05-1 Assistive Technology- Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of members. Assistive technology service means a service that directly assists a member in the selection, acquisition, or use of an assistive technology device.

If authorized, the Department expects that Home Support-Remote Support Hours will be implemented within 90 days of assessment.

Assistive Technology includes;

(A) Assistive Technology-Assessment:

1. The evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the member in the customary environment of the member;

2. The coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

3. The training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member; and

4. The training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members.

Assistive Technology-Assessment is subject to a combined limit per year. See Section 29.07 below.

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29.06 COVERED SERVICES (Cont.)

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(B) Assistive Technology-Devices:

1. The purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members; and
2. The selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

Assistive Technology-Devices is subject to a combined limit per year. See Section 29.07 below.

(C) Assistive Technology-Transmission (Utility Services); the transmission of data required for use of the Assistive Technology Device via internet or cable utility. Assistive Technology-Transmission is subject to a combined limit per month. See Section 29.07 below.

29.05-2 Career Planning is a person centered, comprehensive direct support provided to a member that enables a member to obtain, maintain or advance in competitive employment or self-employment. Career Planning assists with identifying a career direction and developing a plan for achieving competitive, integrated, individual employment or self-employment at or above the State's minimum wage. Services assist in identifying skills, priorities, and capabilities determined through an individualized discovery process. Career Planning may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, and development of experiential learning opportunities and career options consistent with the member's skills and interests. Career Planning may be used in preparation to gather information for a referral to Vocational Rehabilitation.

Effective
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Career Planning is limited to 60 hours annually, to be delivered in a six-month period. No two six-month periods may be provided consecutively. Career Planning services must have the long-term goal of individual, competitive, integrated employment for which the member is compensated at or above the minimum wage. In order to receive Career Planning services, the member's Personal Plan must identify specific career goals and describe how the Career Planning services will be used to achieve those goals.

Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Personal Plan with related goals.

The cost of Transportation related to the provision of Career Planning is a component of the rate paid for the service.

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29.05 COVERED SERVICES (Cont.)

29.05-3 Community Support is Direct Support provided by a Direct Support Professional in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary.

Community Support is intended to be flexible, responsive and provided to members consistent with his or her personal plan.

The location of the service and staffing level may vary, allowing for a mix of individualized and group services. The average staff to member ratio for Community Support for each program location must not exceed 1:3.

Within the scope of Community Support, there may be activities that require that the service be provided in the member's home; most commonly, this will involve the origination or termination of a period of the service. This is allowable as long as it does not duplicate Home Support.

Nothing in this rule prohibits one-to-one (1:1) service delivery.

"On Behalf of" is a component of Community Support; and is included in the established authorization and is not a separate billable service.

A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.

The cost of transportation related to the provision of Community Support is a component of the rate paid for the service and is not separately billable.

The maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours (forty five hundred (4500) quarter hour units) per year. For purposes of this cap, a year is defined as from January 1 to the following December 31.

29.05-4 Employment Specialist Services include services necessary to support a member in maintaining Employment. Services include: (1) periodic interventions on the job site to identify a member's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a member's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job; (3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the Rehabilitation Act and the member is unable to benefit

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29.05 COVERED SERVICES (Cont.)

from Vocational Rehabilitation. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.

Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment agency but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services. The need for continued Employment Services must be documented in a member's Personal Plan as necessary to maintain employment over time.

Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment Specialist Services may be utilized to assist a member to establish and or sustain a business venture that is income producing. MaineCare funds may not be used to defray the expenses associated with the start up or operating a business.

A member may not receive Employment Specialist Services while enrolled in high school.

"On Behalf of" is a component of Employment Specialist Service; and is included in the established authorization and is not a separate billable service.

The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service.

Employment Specialist Services are provided on an intermittent basis with a maximum of 10 (ten) hours each month.

Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.

Employment Specialist Services cannot be provided at the same time as Work Support-Group or Work Support-Individual.

29.05-5 **Home Accessibility Adaptations** are those physical adaptations to the private residence of the member or the member's family, required by the member's Personal Plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home.

Adaptations must not be covered under state plan services, including Section 60, Medical Supplies and Durable Medical Equipment of the MaineCare Benefits Manual and must be determined medically necessary as documented by a licensed

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29.05 COVERED SERVICES (Cont.)

physician and approved by DHHS Office of Aging and Disability Services (OADS). Adaptations commonly include:

- Bathroom modifications
- Widening of doorways
- Light, motion, voice and electronically activated devices
- Fire safety adaptations
- Air filtration devices
- Ramps and grab-bars
- Lifts (can include Barrier-free track lifts)
- Specialized electric and plumbing systems for medical equipment and supplies
- Lexan windows (non-breakable for health & safety purposes)
- Specialized flooring (to improve mobility and sanitation)

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Items not included above but which have been recommended in a Personal Plan are subject to approval by the Department for reimbursement.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this service. All services shall be provided in accordance with applicable State or local building codes. All providers must be appropriately licensed or certified in order to perform this service. This service applies to member owned or a member's family owned home only. Provision of this service in a property owned, rented or leased by an agency is acceptable as long as the adaptation is portable and is the property of the member.

The limit for adaptations is five thousand dollars (\$5,000) in a three (3) year period, with an additional annual allowance up to three hundred dollars (\$300) for repairs and replacement per year. All items in excess of five hundred dollars (\$500) require documentation from a physician or other appropriate professionals such as OT, PT or Speech therapists that the purchase is appropriate and medically necessary to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all requirements of this Section.

- 29.05-6 **Home Support-Quarter Hour** is direct support (billed per unit) provided in the member's home, by a Direct Support Professional to improve and maintain a member's ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with ADLs and/or IADLs, development and personal well-being.

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29.05 COVERED SERVICES (Cont.)

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home. This is allowable as long as it does not duplicate Community Support.

Home Support cannot be provided at a Member's employment site.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

There is no overlap between Assistive Technology and Home Support Remote Support. Assistive Technology provides for the assessment, the equipment and the cost of the monthly transmission. Home Support-Remote Support provides the staff who are monitoring the member.

Home Support-Quarter Hour is limited to 18 hours (72 units ¼ hour) per week.

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29.05-7 **Home Support-Remote Support-** This service provides real time, remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as wells as health monitoring equipment. This assistive technology links each member's residence to the Remote Support provider.

The Remote Support provider has staff available 24 hours per day 7 days per week to deliver direct 1:1 care when needed. If a member chooses this service, the member's Personal Plan must include a safety/risk plan that identifies at least two levels of emergency back-up.

The use of this service is based upon the member's assessed needs and the resulting Personal Plan. The Personal Plan reflects the member's consent and commitment to the plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all assistive technology must be completed prior to the finalization of the Personal Plan with the assistance of the Case Manager and use of appropriate assistive technology consultants.

All Remote Support Services must be provided in real time.

All electronic systems must have back-up power connections to insure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the "Electronic

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29.05 COVERED SERVICES (Cont.)

Communications Privacy Act of 1986". Any services that use networked services must comply with HIPAA requirements.

There is no overlap between Assistive Technology and Home Support Remote Support. As set forth in § 29.05-1, Assistive Technology may be used to provide for assessments, equipment, and the cost of the monthly data transmission utility necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff who are monitoring the member.

There are two types of Remote Support: Interactive Support and Monitor Only. Chapter III reflects the billing for each. Interactive Support includes only the time that staff is actively engaging a member in 1 to 1 direct support through the use of the Assistive Technology Device. Monitor Only is when Assistive Technology equipment is being used to monitor the member without interacting.

Home Support-Remote Support is limited to 18 hours per week (72 units).

29.05-8 **Respite Services** provided to members unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the member. Respite may be provided in the member's home, provider's home or other location as approved by a respite agency or DHHS; example, motel in case of emergency.

29.05-9 **Transportation service** is offered in order to enable members to gain access to Section 29 services, as specified by the Personal Plan. Transportation services for Section 29 services are provided under the MaineCare Benefits Manual, Section 113 (Non-Emergency Medical Transportation Services).

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.

A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.

29.05-10 **Work Support-Group** is Direct Support provided to improve a member's ability to independently maintain employment. Work Support-Group comprises services and training activities that are provided in regular business, industry and community settings for groups of two to six members. Mobile work crews, and business based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed. Work Support-Group must be demonstrably structured and provided in a manner that promotes the integration into the workplace and interaction between members and people without disabilities in those workplaces. The primary focus of the support is job related and also encompasses adherence to workplace

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29.05 COVERED SERVICES (Cont.)

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policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

To receive this service, a member must have received an assessment and services under the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act and need for on-going support must have been determined and documented in the Personal Plan. The outcome of this service must be sustained paid employment and work experience leading to further career development and individual integrated community based employment for which the member is compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Work Support-Group does not include vocational services provided in a facility-based work setting in specialized facilities that are not part of the general workforce.

Work Support-Group may be used to support a member in a job that pays less than the minimum wage only if the employer complies with section 14(c) of the Fair Labor Standards Act (29 U.S.C. § 214(c)) and 26 M.R.S. § 666.

Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Work Support-Group does not include volunteer work.

Work Support-Group cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.

The cost of transportation related to the provision of Work Support-Group is a component of the rate paid for the service.

The combination of Work Support-Group and Work Support-Individual may not exceed 600 hours per year. Where the member receives a combination of Community Support, Home Support, Work-Support-Group and/or Work Support-Individual services, the combined cost of Community Support, Home Support, Work Support-Individual, and Work Support-Group may not exceed \$23,771.00 annually.

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29.05 COVERED SERVICES (Cont.)

Information must be provided to the member at least yearly that career planning and individual employment are available to them in order to make an informed decision.

29.05-11 Work Support-Individual is Direct Support provided to improve a member's ability to independently maintain employment. Work Support-Individual is provided in an employment setting as defined in 29.02-9 and may be provided in a member's home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services.

Work Support-Individual must be provided to members in an integrated employment setting in the general workforce and the member must be compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

A member may not receive Work Support while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment.

This service is provided after a member has received an assessment and services under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act and need for on-going support has been determined and documented in the Personal Plan. Work Support-Individual may be provided to self-employed members where the member requires support in operating his or her own business. Support may be used for Customized employment for members with severe disabilities – to include long term support to successfully maintain a job due to the ongoing nature of the member's support needs, changes in life situation, or evolving and changing job responsibilities. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Work Support-Individual does not include volunteer work.

“On Behalf of” is a component of Work Support-Individual and is included in the established authorization and is not a separate billable service.

Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

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29.05 COVERED SERVICES (Cont.)

Work Support-Individual cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.

The cost of transportation related to the provision of Work Support is a component of the rate paid for the service.

The maximum annual allowance for Work Support-Individual is six hundred (600) (twenty four hundred (2400) quarter hour units) hours. For purposes of this cap, a year is defined as from July 1 to the following June 30. Where the member receives a combination of Community Support, Home Support, Work-Support-Group and/or Work Support-Individual services, the combined cost of Community Support, Home Support, Work Support-Individual, and Work Support-Group may not exceed \$23,771.00 annually.

29.07 NON COVERED SERVICES

Services for which reimbursement is not allowed under this Section include, but are not limited to, the following:

- 29.06-1 Services not identified by the Personal Plan;
- 29.06-2 Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;
- 29.06-3 Services to any member who is a nursing facility resident, or ICF/IID resident;
- 29.06-4 Services that are reimbursable under any other sections of the MaineCare Benefits Manual;
- 29.06-5 Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including but not limited to job development and vocational assessment or evaluations;
- 29.06-6 Room and board; The term "room" means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day; or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member's home. Board also does not include the delivery of a single meal to a member at his/her own home through a meals-on-wheels service;

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29.06 NON-COVERED SERVICES (Cont.)

- 29.06-7 With the exception of transportation, services covered under 29.05-5, services provided directly or indirectly by a person legally responsible for the member, including the member's spouse or a member's parents, stepparents, or guardian. A guardian who is unrelated cannot be directly or indirectly reimbursed for services;
- 29.06-8 Work Support-Individual or Work Support-Group or Employment Specialist Services when the member is not engaged in employment;
- 29.06-9 Home Accessibility Adaptations unless the service has been determined non reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual;
- 29.06-10 A member may not have wages from employment paid for with MaineCare reimbursement: and
- 29.06-11 Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member's parent, sibling or other biological family member. This rule will not be avoided by adult adoption.

29.07 LIMITS

- 29.07-1 MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time.
- 29.07-2 The combined annual limit for members who receive Home Support (Remote or ¼ hour), Community Support, Work Support-Individual or Work Support-Group, Assistive Technology and Career Planning is Twenty three thousand, seven hundred and seventy one dollars (\$23,771.00).
- 29.07-3 Home Support-Quarter Hour is limited to 18 hours (72 units ¼ hour) per week. Home Support-Remote Support is limited to 18 hours per week (72 units).
- 29.07-4 The maximum annual allowance for Community Support is eleven hundred and twenty five (1,125) hours (forty five hundred (4500) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30.
- 29.07-5 Employment Specialist Services are provided on an intermittent basis with a maximum of ten (10) hours (forty (40) quarter hour units) each month.
- 29.07-6 The maximum annual allowance for Work Support-Individual or Work Support-Group is not to exceed six hundred (600) hours (twenty four hundred (2400) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30.

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29.07 LIMITS (Cont.)

- 29.07-7 Home Accessibility Adaptations are limited to five thousand dollars (\$5,000) in a three (3) year (thirty six (36) months) period with an additional annual allowance up to three hundred dollars (\$300) for repairs and replacement per year. General household repairs are not included in this service. All items in excess of five hundred (\$500) dollars require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit can be reimbursed under this section.
- 29.07-8 A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.
- 29.07-9 Respite Services are limited to one thousand dollars (\$1000.00) per year. Additionally, the quarter hour (1/4) billing for Respite shall not exceed the per diem limit of (Ninety dollars (\$90.00) for each date of service. Reimbursement for Respite is a quarter (1/4) hour billing code. After thirty three (33) quarter hour units of consecutive Respite Services, the provider must bill using the per diem billing code. The quarter hour (1/4) Respite amount billed any single day cannot exceed the Respite per diem rate of Ninety (\$90.00) dollars.
- 29.07-10 Services reimbursed under this section are not available to members who reside in an ICF/IID, nursing facility or are inpatients of a hospital.
- 29.07-11 A member may not receive services that are comparable or duplicative under another Section of the MaineCare Benefits Manual at the same time as services provided under this waiver benefit. Such comparable or duplicative services include, but are not limited to services covered under the MaineCare Benefits Manual, Section 2, Adult Family Care Services; Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 21, Home and Community Benefits for Person with Intellectual Disabilities or Autistic Disorder; Section 22, Home and Community Benefits for the Physically Disabled; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 45, Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/IID Services; Section 67, Nursing Facility Services and Section 97, Private Non-Medical Institution Services.
- 29.07-12 A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.
- 29.07-13 A member may not receive Employment Specialist Services while enrolled in high school.

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29.07 LIMITS (Cont.)

- 29.07-14 A member may not receive Work Support-Individual or Work Support-Group while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment.
- 29.07-15 Work Support Services are limited to one Direct Support Professional per member at a time.
- 29.07-16 The total amount of Services authorized may not exceed 50% of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.
- 29.07-17 If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening.
- 29.07-18 Assistive Technology services are not covered under this rule if they are available under another MaineCare rule. Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, is subject to a combined limit of \$6,000 per year. Assistive Technology-Transmission (Utility Services) is subject to a combined limit of \$50 per month.
- 29.07-19 Career Planning is limited to 60 hours annually to be delivered in a six-month period. No two six-month periods may be provided consecutively.

29.08 DURATION OF CARE

Each member receiving services under this Section is eligible for as many covered services as are authorized by DHHS in the member's personal plan. Services are authorized to meet the needs identified in the member's most recent assessment, subject to limits on covered service components specified elsewhere in this Section.

- 29.08-1 Voluntary Termination-** A member who currently receives the benefit, but no longer wants to receive the benefit, will be terminated, after DHHS receives written notice from the member that he or she no longer wants the benefit.
- 29.08-2 Involuntary Termination-**DHHS will give written notice of termination to a member at least ten (10) days prior to the effective date of the termination, providing the reason for the termination, and the member's right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

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29.08 DURATION OF CARE (Cont.)

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- A. The member has been determined to be financially or medically ineligible for this benefit or MaineCare;
- B. The member has been determined to be a nursing facility resident or ICF/IID resident without an approved Personal Plan to return to his or her home;
- C. The member has been determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;
- D. The member is no longer a resident of the State of Maine;
- E. The health and welfare of the member can no longer be assured because:
 - 1. The member or immediate family, guardian or caregiver refuses to abide by the Personal Plan or other benefit policies;
 - 2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or
 - 3. There is no approved Personal Plan.
- F. The member has not received at least one service in a thirty (30) day period; or
- G. The annual cost of the member's services under this waiver exceeds fifty percent (50%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.

29.08-3 Provider termination from the MaineCare program- The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.

29.08-4 After a member is determined eligible for this waiver, if there is any one (1) month period during which the member does not receive a waiver service, the case manager must include a note in the record indicating;

- A. The reason a waiver service was not provided,
- B. Whether the member continues to need services provided in the waiver.

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29.09 MEMBER RECORDS

Each provider serving the member must maintain a specific record for each member it serves in accordance with the requirements of Chapter I of the MaineCare Benefits Manual. The member's record is subject to DHHS's review.

In addition, the member's records must contain:

- A. The member's name, address, birth date, and MaineCare identification number;
- B. The member's social and medical history, and diagnoses;
- C. The member's Personal Plan; and
- D. Written progress notes that identify any progress toward the achievement of the goals, services and needs established by the member's Personal Plan signed by the staff performing the service.

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DHHS will conduct a review of provider records that may include, but is not limited to, staff schedules, payroll records and member records to substantiate service delivery and units of authorization.

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS

The provider must document each service provided, the date of each service, the type of service, need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service.

To provide services under this section a provider must be a qualified vendor as approved by DHHS and enrolled by the MaineCare program. Once a provider has been authorized to provide services, the provider cannot terminate the member's services without written authorization from DHHS.

29.10-1 **Direct Support Professional (DSP)** is a person who provides Home Support-Quarter Hour, Home Support-Remote Support, Community Support, Career Planning or Work Support and has successfully completed the Direct Support Professional curriculum as adopted by DHHS, or DHHS's approved Assessment of Prior Learning, prior to July 1, 2011 or has successfully completed the Maine College of Direct Support. The Maine College of Direct Support is accessed on the internet at: <http://www.maine.gov/dhhs/oads/disability/ds/cds/index.shtml> All DSP staff must:

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- A. Have a background check consistent with Section 29.10-4;
- B. Have an adult protective and child protective record check;
- C. Be at least eighteen (18) years of age; and

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29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (Cont.)

- D. Have graduated from high school or acquired a GED: and
- E. Completed the following four modules from the College of Direct Support prior to providing services to a member alone:
1. Introduction to Developmental Disabilities
 2. Professionalism
 3. Individual Rights and Choice
 4. Maltreatment
- Documentation of completion must be retained in the personnel record.
- F. A DSP who also provides Work Support- Individual or Work Support-Group must have completed the additional employment modules in the Maine College of Direct Support in order to provide services.
- G. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional 6 hours of Career Planning and Discovery training provided through Maine's Workforce Development System.

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All new staff or subcontractors must complete the Maine College of Direct Support within six (6) months of actual employment from date of hire. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor. Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

A person who provides Direct Support must be a DSP regardless of his or her status as an employee or subcontractor of an agency. A DSP can supervise another DSP.

Only a DSP who is certified as a Certified Nursing Assistant-Medications (CNA-M), a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN) may administer medications to a member.

29.10-2 **Employment Specialist** is a person who provides Employment Specialist Services or Work Support and has:

- A. Successfully completed the Maine Employment Curriculum for Employment Specialist Certification as approved by DHHS. (approved courses are listed at: <http://www.employmentforme.org/providers/crp-training.html>) Certification must occur within six (6) months of hire;
- B. Supervision during the first six months of hire from a Certified Employment Specialist in order to provide services;

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29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (Cont.)

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- C. Graduated from high school or acquired a GED;
- D. Satisfied a background check consistent with Section 29.10-4; and
- E. Worked for a minimum of one (1) year with a person or persons having an Intellectual Disability or Autism in a work setting.

29.10-3 **Emergency Intervention-** All providers must follow DHHS's rule governing emergency intervention and behavioral treatment for persons with Intellectual Disabilities (14-197 CMR Chapter 5, 2007), and must meet training requirements on approved behavioral interventions procedures (e.g.,Mandt) if applicable and indicated as a need in the member's Personal Plan.

29.10-4 **Background Check Criteria-**The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

- A. any criminal conviction that involves abuse, neglect or exploitation;
- B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;
- C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or
- D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years; or
- E. any criminal conviction within Title 29-A, chapter 23, subchapter 2, article 1, or Title 29-A, chapter 23, subchapter 5.

Employment of individuals with records of such convictions more than five (5) years ago is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The provider shall contact child and adult protective services (including the Office of Aging and Disability Services) units within State government to obtain any record of substantiated

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29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (Cont.)

allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards.

Providers are not required to obtain records from child protective services for employees who do not provide services to children.

29.10-5 Informed Consent Policy

Providers must put in place and implement an informed consent policy approved by the Department. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider's informed consent policy must ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

29.10-6 Reportable Events

Providers shall comply with all terms and conditions of the Department's Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings regarding persons with Intellectual Disabilities or Autism as described in 14-197 CMR, chapter 12. All staff must receive training in mandatory reporting/reportable events either before they begin work with members or, at the latest, within thirty (30) days of being hired.

29.11 APPEALS

In accordance with Chapter I of the MaineCare Benefits Manual, members have the right to appeal in writing or verbally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. The right to appeal does not extend to changes in law or policy adversely affecting some or all recipients. The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1-800-606-0215 or TTY:711.

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29.11 APPEALS(Cont.)

Office of Aging and Disability Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

29.12 REIMBURSEMENT

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 29, Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder or the provider's usual and customary charge, whichever is lower.

DHHS will conduct a review of provider records that may include, but is not limited to, staff schedules, payroll records and member records to substantiate service delivery and units of authorization.

29.13 BILLING INSTRUCTIONS

Providers must bill in accordance with DHHS billing instructions.

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29.14 APPENDIX I-Guidelines for Approval of Medical Add-On in Maine Rate Setting

The purpose of this Appendix is to detail guidelines for Office of Aging and Disability Services personnel in approving a Medical Add-On to the established published rate. All current statutes, regulations, decree provisions, policies, and licensing standards regarding medical services are unaffected by these guidelines. This Appendix develops criteria that warrant an adjustment to the Department's established published rate for Community Support, Employment Specialist Services and Work Support Services.

The following standards and practices must be demonstrated in order for the Department of Health and Human Services to approve a Medical Add-On:

A. Physician Order

1. There must be a written physician's order for the member. This order must specify:
 - a. The specific illness or condition to be addressed;
 - b. The specific procedure(s) that will be utilized;
 - c. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;
 - d. The anticipated frequency of treatment or intervention on a daily, weekly, or monthly basis;
 - e. Where applicable and possible:
 1. The approximate length of time required for each episode of the treatment or intervention and
 2. The degree of licensure or certification required for those who carry out the treatment, and those who provide training and oversight relative to its application.

B. Planning Team

1. The team must meet or otherwise confer for the following purposes:
 - a. To determine whether the setting where the member is served is appropriate to carry out the physician's recommended treatment or intervention;
 - b. To determine how the member's needs shall be met and what the staffing requirements are.

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29.14 APPENDIX I - Guidelines for Approval of Medical Add-On in Maine Rate Setting (Cont.)

2. All of these determinations and recommendations must be noted in the Personal Plan, or in an amendment to an existing Personal Plan.

C. Provider Requirements

1. The provider must be an enrolled MaineCare provider.
2. For any physician order specifying a skilled medical professional who shall train, monitor, or deliver treatment, the provider must have regular access to the professional, either as an employee, or via a contract, or via an established relationship; or alternatively, the provider must be able to gain this access in a time frame commensurate with the treatment requirements.

D. Approval Process

1. The DHHS or Authorized Entity will issue a written decision for the Medical Add-On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information DHHS or Authorized Entity will approve or deny the request within ten (10) working days.
2. Documents will be reviewed by a designated representative.
3. Approvals will include a specification of the authorized daily or weekly units of service which require the Medical Add-On. In special circumstances, approval may be retroactive to the date of application of the Add On based on documentation.
4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed at minimum, annually by the team. Verification of this continued need must be provided to the DHHS or Authorized Entity within a year of the original approval, in order for the Medical Add-On to continue.

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29.15 APPENDIX II - “On Behalf Of” Covered Services

“On Behalf Of” Covered Services:

Support and supervision that is offered whenever the staff and the member are in the same physical environment is considered *direct support time*. This would include, for example, staff waiting for a member during a medical appointment or a home visit. Examples of acceptable services include:

Services and time that are directly related to a member: such as scheduling medical appointments, dental appointments and therapy appointments. This includes any time staff may need to spend discussing with a physician, dentist, or therapist any intervention regarding the member.

Services and time that are directly related to a member that are associated with that member’s personal plan, medical plan or behavioral plan including in-service training specific to a member’s personal plan, consultations with supervisors, therapist, clinicians, member’s employer and or medical staff; services relating to a member’s parent, guardian or Maine Developmental Services Oversight and Advisory Board (MDOAB) representative; documentation, reports and presentations to review committees.

Services and time that are directly related to a member that are associated with home visits, family events and or family reunification including transporting a member to their parents, guardian, or friends home for visits, returning a member to their home, and any time spent during such a visit such as attending a family function with the member.

Services and time that are directly related to a member’s safety such as “shadowing” a member as he or she learns to take a bus.

“On Behalf Of” Non-Covered Services:

Services and time that are related to group services, or time that cannot be directly linked to member’s Personal Plan. For example, grocery shopping for a home.

Services and time that are related to home cleaning, home maintenance, facility cleaning or facility maintenance.

Services and time that are related to staff training, unless the training is specific and exclusive to the member.

Services and time that are related to landscaping, snow removal, spring clean-up or similar activities.

Services and time that are related to securing or maintaining a license or certificate such as a group home license, or CARF accreditation.

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29.15 APPENDIX II - “On Behalf Of” Covered Services (Cont.)

Services and time that are related to staff recruitment, even if the staff is being recruited for the member.

Services and time provided by a salaried staff member unless there is evidence that the salaried staff was working as a Direct Support Professional for the time being claimed.

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29.16 APPENDIX III Performance Measures

Effective 9/1/14 The primary goal of Performance Measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance Goals and Performance Measures assist to monitor quality, inform and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on Performance Measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

29.16-1 Performance Goals

Members receiving this service will experience improved or preserved functional abilities while being able to live in a safe and stable setting within the community.

29.16-2 Performance Measures

- a. 65% of members receiving Work Support-Individual services will have worked a total number of hours of paid employment during the quarter that is greater than the total number of Work Support-Individual support hours they received during the quarter.
- b. 100% of members receiving Work Support Services-Group making less than minimum wage, will have a Personal Plan in place that identifies how Work Supports is being utilized to increase the member's productivity and ensure good job match in order to move toward an hourly wage that meets or exceeds the State of Maine minimum wage standard.

29.16-3 Performance Measure Data Source

Providers must electronically enter individual level data into a DHHS defined web-based data collection system by the ~~second Friday~~ fifteenth of the month after the quarter ends.

29.16-4 Performance Measurement Compliance

DHHS may exercise the following steps to ensure compliance:

Step 1: DHHS will notify the Provider in writing of any compliance and performance issues identified by DHHS staff. The notice will include the performance provision that is in noncompliance and a date by which the provider will correct or remedy the identified non-compliance/performance issue.

Step 2: If the compliance/performance issues described by DHHS in Step 1 have not been addressed by the specified dates, the Provider and a representative of DHHS will meet, discuss, and document the compliance/performance issues. DHHS and the Provider will develop a corrective action plan which must include:

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29.16 APPENDIX III Performance Measures (Cont.)

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1. A statement of the corrective actions required for compliance with the Performance Measures;
2. The date by which the Provider will comply with the terms of the Performance Measures;
3. The consequences for non-compliance which may include the sanctions described in Chapter I of this manual or other consequences as determined by the Department; and
4. Signatures of the Provider and DHHS representative.

Step 3: In accordance with Chapter I, if the Provider fails to undertake the corrective actions in the corrective action plan, DHHS may impose sanctions, up to and including termination of the Provider Agreement in accordance with the procedures described in Chapter I, General Administrative Policies and Procedures, Section 1.03-4, Termination of Participation by Provider or DHHS and Section 1.19, Sanctions/Recoupments.